Exhibit 9

THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

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IN RE: PHARMACEUTICAL	MDL DOCKET NO.
INDUSTRY AVERAGE WHOLESALE	01CV12257-PBS
PRICE LITIGATION	
**********	MARCH 1, 2006
THIS DOCUMENT RELATES TO:	VOLUME: V
ALL ACTIONS	PAGES: 1169-1469

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C O N F I D E N T I A L

CONTINUED VIDEOTAPED DEPOSITION OF RAYMOND S. HARTMAN, PH.D., called as a witness by and on behalf of the Defendants, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Dwyer & Collora, LLP, 600 Atlantic Avenue, Boston, Massachusetts, on Wednesday, 1 March, 2006, commencing at 9:46 a.m.

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APPEARANCES:

HAGENS, BERMAN, SOBOL & SHAPIRO
BY: Edward Notargiacomo, Esq.
David S. Nalven, Esq.
One Main Street, 4th Floor
Cambridge, MA 02142
617 402-3700
ed@hbsslaw.com / davidn@hbsslaw.com
For the Plaintiffs

HOGAN & HARTSON, L.L.P
BY: Steven M. Edwards, Esq.
Hoa T.T. Hoang, Esq.
James S. Zucker, Esq.
Colleen Scott, Esq. (Via telephone)
875 Third Avenue
New York, NY 10022
212 918-3506
smedwards@hhlaw.com / htthoang@hhlaw.com
jszucker@hhlaw.com
For Defendant Bristol-Myers Squibb

1171

APPEARANCES: (Continued)

DAVIS, POLK & WARDWELL
BY: Michael S. Flynn, Esq.
450 Lexington Avenue
New York, NY 10017
212 450-4000
michael.flynn@dpw.com
For Defendant Astra Zeneca Pharmaceuticals Corp.

ROPES & GRAY, L.L.P.
BY: Steven A. Kaufman, Esq.
Kim B. Nemirow, Esq.
John Montgomery, Esq.
One International Place
Boston, MA 02110-2624
617 951-7000
steven.kaufman@ropesgray.com
kim.nemirow@ropesgray.com
For Defendant Shering Corporation/
Shering Plough

1172

APPEARANCES: (Continued)

SHOOK, HARDY & BACON, L.L.P.
BY: James P. Muehlberger, Esq.
Tiffany W. Killoren, Esq.
2555 Grand Boulevard
Kansas City, MO 64108-2613
816 474-6550
jmuehlberger@shb.com
tkilloren@shb.com
For Defendant Aventis Pharmaceuticals

PATTERSON, BELKNAP, WEBB & TYLER, L.L.P.
BY: Adeel A. Mangi, Esq.
William Cavanaugh, Esq.
1133 Avenue of the Americas
New York, NY 10036-6710
212 336-2000
aamangi@pbwt.com
For Defendant Johnson & Johnson

(CONTINUED)

1173

APPEARANCES: (Continued)

DECHERT L.L.P.
BY: Frederick G. Herold, Esq.
1117 California Avenue
Palo Alto, CA 94304-1106
650 813-4800
frederick.herold@dechert.com
For GlaxoSmithKline

MORGAN, LEWIS & BOCKIUS, L.L.P.
BY: J. Clayton Everett, Jr., Esq.
1111 Pennsylvania Avenue, N.W.
Washington, DC 20004
202 739-5860
jeverett@morganlewis.com
BY: Jason Baranski, Esq.
1701 Market Street
Philadelphia, PA 19103
jbaranski@morganlewis.com
For Pharmacia Corporation of the
State of Connecticut

APPEARANCES: (Continued)

KIRKLAND & ELLIS, L.L.P.
BY: Helen E. Witt, Esq.
200 East Randolph Drive
Chicago, IL 60601
312 861-2148
hwitt@kirkland.com
For Defendant Roxane in the Connecticut case

APPEARING VIA TELEPHONE:

COVINGTON & BURLING
BY: Mark Lynch, Esq.
1201 Pennsylvania Avenue NW
Washington, DC 2004-2401
202 662-5685
mlynch@cov.com
For GlaxoSmithKline

(CONTINUED)

APPEARING BY TELEPHONE: (Continued)
ALSO PRESENT:
Chris Stromberg, Esq.
Bates White
2001 K Street, N.W, Suite 700
Washington, D.C. 20006
202 216-1142 / chrisstromberg@bateswhite.com

William B. Tye
The Brattle Group
44 Brattle Street
Cambridge, MA 02138-3736
617 864-7900 / btye@brattle.com

Timothy S. Snail, Principal
CRA International
John Hancock Tower
200 Clarendon Street, T-33
Boston, MA 02116-5092
617 425-3000

Ralph Scopa, Videographer

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EXHIBITS

VIDEO OPERATOR: Good morning. We are now recording and on the record. Today's date is March 1st, 2006. This is the continuation of the deposition of Dr. Raymond Hartman.

MR. NALVEN: We have presented Doctor Hartman for two days in the MDL proceeding. The State of Connecticut designated today as a day for Connecticut-specific questioning of Doctor Hartman. The MDL Defendants have taken the position that they are entitled to continue with Doctor Hartman's deposition today, notwithstanding that they have had two days to depose Doctor Hartman in connection with class cert. and two additional days to depose him most recently. Mr. Cavanaugh is occupying the questioner's chair, and so, we will permit Doctor -- the MDL Plaintiffs to continue their questioning until the next break this morning, at which time we will reconsider whether the MDL questioning has become so burdensome and so objectionable as to cause us to require that it end.

We did represent both to the Connecticut

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Defendants and, in turn, to the Court that today would be available for Connecticut-specific questioning, and we intend to abide by that commitment. So, Mr. Cavanaugh, you're free to proceed.

MR. CAVANAUGH: Let me just note, Mr. Cavanaugh occupied the seat at 9:20, was prepared to begin questioning the witness at 9:30. It's now 9:46.

RAYMOND S. HARTMAN, Ph.D., having been previously sworn, testified as follows to interrogatories

BY MR. CAVANAUGH:

Q. Good morning, Doctor Hartman. Doctor Hartman, your initial and supplemental reports with respect to Johnson & Johnson address two physician-administered drugs sold by Johnson & Johnson Companies, Remicade and Procrit, correct?

A. Let me check to confirm that. That's correct.

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Q. Is it your understanding that Remicade was introduced in 1998?

A. I will look to see when I have data from the company.

Q. Why don't you pull out G-4 with -- the section dealing with Johnson & Johnson.

A. That's just where I was going.

Q. Okay.

A. I have Section G-4. I'm seeing Remicade appearing in the -- from the invoice data that we received from Johnson & Johnson, and it is my understanding, based on this and no additional notes -- let me just check whether there was missing data -- (Witness reviews document.)

Q. Doctor Hartman, to save time, for purposes of my question, simply assume that Remicade was introduced in 1998.

A. Okay.

Q. Okay? Did the various pricing services such as Redbook and First Data Bank report an AWP and a WAC for Remicade?

A. The -- the various sources, both Redbook

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and I would -- and First Data Bank certainly reported an AWP. I would assume they reported a WAC. I don't know whether they reported a WAC.

Q. Would you agree with me that the information in Redbook and First Data Bank with respect to Remicade, its AWP, and its WAC was information that was widely available?

A. I would.

Q. And would you agree with me that is certainly information that was available to third-party payers?

A. Yes.

Q. Was that also information that third-party payers would review from time to time?

MR. NALVEN: Objection.

A. I would -- I would assume -- it was information available. To the extent they reviewed it, I can't comment. I'd be speculating.

Q. Doctor Hartman, is it your opinion that the published information on Remicade's AWP and WAC was the type of information that contributed to the expectation of third-party payers as to the

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prices at which physicians were acquiring Remicade?

A. As I've stated throughout the AWP and WAC are list prices that are signals that -- that inform the expectations as to transactions prices, such as acquisition costs.

Q. Is it your opinion that third-party payers expected that physicians were buying Remicade at or about the published WAC?

A. The -- the expectations that -- of physicians regarding any physician-administered drugs, I have -- I've summarized the information that is the basis for my yardstick, and that summarizes what was the understanding, and the market informed the reimbursement policies that reflected an understanding what the acquisition cost was.

Q. Doctor Hartman, I'm asking you specifically with respect to Remicade, is it your opinion that third-party payers expected that physicians were buying Remicade at or about the published WAC?

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MR. NALVEN: Asked and answered.
A. If WAC were within the -- the yardsticks, then that would -- that would mean that it -- that was their expectations.
Q. Is it your opinion that third-party payers expected that physicians, on average, were acquiring Remicade at prices a few percentages below the published WAC?
A. I've laid out what my expectations are. It's -- they're related to what an acquisition cost is and AWP.
Q. Is it your opinion that third-party payers which directly received rebates on Remicade would understand that physicians may have also been acquiring Remicade below WAC based on receiving rebates?
MR. NALVEN: Objection.
A. It's my understanding that for the drugs that reached providers -- physician-administered drugs reaching providers, that the extent that rebates were paid to third-party payers were -- were quite small.

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Q. And so, would it have been reasonable for a third-party payer to believe that physicians may have been receiving rebates in that same range as the third-party payers?
MR. NALVEN: Objection.
A. I've laid out what my -- what my expectations are for all physician-administered drugs, and we've discussed it at length the last two days.
Q. What was the published spread between WAC and AWP for Remicade?
A. I don't have -- I could -- I could find that out, but I haven't -- and I may have looked at that, but I don't recall.
Q. I'm going to ask you to assume that it's 30 percent, okay?
A. Okay.
Q. So that -- would you agree with me that that information was certainly available to third-party payers?
MR. NALVEN: Objection.
A. If that was the spread, then that --

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third-party payers would understand that, that's correct.
Q. Did Centocor provide rebates to physicians?
A. Centocor as --
Q. I'm sorry. Do you understand that Centocor is the Johnson & Johnson company that sells Remicade?
A. I -- I understood that Centocor was one of the -- was related -- was a subsidiary or a -- in the family of Johnson & Johnson. I didn't realize they were the ones that distributed Remicade. So, that being established, please --
Q. Did Centocor provide rebates to physicians with respect to Remicade?
A. In the data that I've reviewed across the physician-administered drugs, I found that rebate amounts were de minimis in the -- rebates characterized as rebates. Whether they paid other kinds of price offsets or other kinds of payments -- but in the traditional definition of rebates as the kinds of payments offered to PBMs or third-

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party payers, those kinds of payments were quite small for across the board.
Q. Were you aware that the Plaintiffs in this case have admitted that Centocor provided no rebates to physicians on Remicade?
MR. NALVEN: Objection.
A. I don't recall one way or the other.
Q. So, that's not information that was shown to you by the Plaintiffs?
MR. NALVEN: Objection.
A. Well, it was information --
MR. NALVEN: You can answer.
A. In terms of the data, the data was -- we asked for the data on rebates from Johnson & Johnson and Centocor. So, we received data on all rebates paid and any payments -- any other payments, and those are reflected in the ASP calculation. So that I certainly asked for that information. It was produced to me. I -- I wanted to incorporate it. Did I look at that data specifically from Centocor for that drug? I had my staff incorporate that into the definitions of

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the -- of the ASP and the spreads there -- thereto.

Q. So, you've -- so, your conclusion that rebates were paid to physicians on Remicade is based upon the ASP analysis you've done in G-4?

A. To the extent that there have been any price offsets offered by Centocor/Johnson & Johnson for any of their drugs and for Remicade in particular, they would be reflected and incorporated into the calculations of ASP, as done in -- in the -- in the declaration.

Q. Did you at any point look to see what the discovery record was on whether, in fact, rebates had been provided to physicians?

MR. NALVEN: Objection.

A. I certainly asked my staff to do an analysis drug by drug on what was the extent to which rebates appeared in the invoice or rebate databases that we received, and I reviewed -- I reviewed them drug by drug, but I -- you know, I don't remember anything in terms of deposition material that I -- that I focused on specifically.

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I looked at -- I let the numbers tell me what was going on.

Q. Now, if you saw an admission by the Plaintiffs that based on their review of the discovery record no rebates had been provided to physicians on Remicade, would that have caused you to go back and look a little bit more carefully at your Remicade calculations?

MR. NALVEN: Objection.

A. Well, you're -- there's -- rebates are one of many ways that manufacturers can provide financial incentives to providers, and, you know, there's the -- in the matter of Lupron, there were payments in terms of consulting fees and educational grants and a whole variety of financial incentives offered that looked like a rebate. They were dollar amounts. They weren't called rebates, so --

Q. It's --

A. -- I've looked at all the types of financial incentives that were offered on these drugs and maybe they were called rebates or maybe

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not.

Q. What financial incentives were provided to physicians --

A. The -- the --

Q. -- on Remicade?

A. I would have to -- the -- let's go back and look at the data that was presented for your client. (Witness reviews document.) Okay. So, we have the data file -- I'm looking at Page 2 of G.4.D., which is a description of the file list and sources of data that we had received from Johnson & Johnson, and I'm looking through what we received -- we received information on direct sales for Remicade. Then there are charge-back data that we received, and there are charge-back data files and contracts relating to Remicade on Page 7 of that attachment.

Q. Doctor Hartman, would I be correct that your calculation of the ASP for Remicade in your initial report sought to exclude charge-backs, discounts provided to any class of trade other than physicians?

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A. The -- the types of rebate -- any kind of financial incentives that did not go to providers using the information you provided us, we attempted to exclude them. That's correct. But that --

Q. So --

A. -- means that I still see rebate data here, I see charge-backs, and wherever any of those did relate to -- to Remicade, those were included. And for me to answer your question, I'd have to have them -- have my staffing back and reproduce whatever those data files told me were the amounts.

Q. So, it was not your intention to include in charge-back or rebate data, charge-back and rebates given to entities such as Humana or Kaiser?

A. We excluded staff HMOs or direct purchasers like Kaiser.

Q. And it would not have been your intention to include contracts which provided for charge-backs or rebates that Centocor may have had

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with the federal government?
A. We excluded the federal government.
Q. And the same would be true with respect to contracts with the public health service?
A. That's correct.
Q. And if any of those -- if any of that data made its way into your calculation, that would be an error, wouldn't it, Doctor?
MR. NALVEN: Objection.
A. It -- it would be something I would want to look at and see -- again, we did -- we tried to accomplish just what we've just said based on information we received from each of the Defendants. And I'd have to see how precise that information were. If it -- if we were provided with the sufficient information and we didn't act on it, that would be an error. If we didn't get sufficient information, then it was something we couldn't -- couldn't do.
Q. Let me ask you to turn to your -- to G.4.C, which is your calculation of the spreads for Remicade.

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A. I'm there.
Q. And I'd ask you to assume that the published spread in the pricing services between AWP and WAC was 30 percent, okay?
A. I'm -- yeah. We've already assumed that.
Q. Is it your opinion that given that there was a 30-percent spread published and available to third-party payers, that 30 -- third-party payers would have been, in your own words, flabbergasted to learn that the spread between the actual selling price and AWP was actually 31.9 percent in the year 2000?
MR. NALVEN: Objection.
A. Well, a number of -- of comments thereto. First of all --
Q. Can you answer that question --
A. -- flabbergasted --
Q. -- that question yes or no?
MR. NALVEN: Objection.
A. It's -- it's not a question that can be answered yes or no.

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Q. Okay.
A. The -- you're talking -- first of all, you've said, in my words, flabbergasted. Those are not my words.
Q. You used the word "flabbergasted" yesterday, Doctor.
A. Citing an Advance PCS staff member who was reviewing spreads and was put in front of him. So, it's not my words. I was using words of people in this industry that were flabbergasted. And secondly, the kinds of spreads for which they were flabbergasted, this is not a flabbergasting spread. It is a spread in excess of the yardstick, and the -- the industry un -- let me finish. The industry does understand that there are transaction -- there are list prices, AWP, and WAC, but the industry also understands that there are other financial incentive payments, either off or on top of or reducing that or increasing the ASP around WAC or whatever it happens to be that are not transparent to payers, and those are -- those are special deals between the manufacturer

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and the people to whom Centocor sells Remicade. And so, the fact that there's a spread of 31.9 indicates that this -- on this drug -- Centocor was exceeding the speed limit by a small amount, not a flabbergasting amount. This is not -- this wouldn't merit a speeding ticket of $500 as a flabbergasting spread might, but there is -- there is -- there is a -- the -- on these spreads they do exceed what the payers understood the relationship between AWP and ASP to be.
Q. Well, Doctor, we're assuming now that the published spread -- if I go to a pricing service, I see the published spread on Remicade between AWP and WAC is 30 percent --
A. Right.
Q. -- and you've just told me that third-party payers understood that there's transactional discounts and other things provided that -- of a couple of percentage points, correct?
MR. NALVEN: Objection.
Q. So, wouldn't it be reasonable for a third-party payer to have assumed that if you have

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a published spread of 30 percent, that the actual acquisition price might vary by a couple of percentage points off of WAC?

MR. NALVEN: Objection.

A. We've -- we've already established the fact that there are -- there are list prices in this market. We've already, secondly, established the fact that payers focus primarily for list prices and reimbursement not on WAC but on AWP.

The analyses that I have focused on and developed -- for which I've developed yardsticks are a relationship between AWP and ASP. The fact that there's -- that there is a WAC available may provide certain information, but it's also clear that there's -- there's a variety of payments that are unclear to third-party payers that -- there's an understanding of what the -- what they -- the levels that they might be. But the key thing is the third-party payers would not know what those are, and the spreads -- even though the WAC is -- is -- was -- the relationship between WAC and AWP was 30 percent, it could turn out that the ASP

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might have been 29 percent.

It's -- there -- whatever the kinds of payments that were -- or incentives or financial arrangements between Centocor and the doctors is what's not transparent to the payers.

And so, all they can ultimately look -- think about is what's the relationship to the acquisition cost, which is not -- not necessarily WAC. It's going to be ASP. And that's what I've -- that's what I focused on.

Q. And so, a relationship -- do you think it is reasonable for third-party payers to have believed that the relationship between WAC and ASP might differ by a couple of percentage points?

MR. NALVEN: Objection.

A. The -- the relationships that I focused on have been the relationships between AWP and ASP, and given the fact that there is strict formulaic relationship by drugs between AWP and a WAC, and the usual ones are 20, 25 percent above -- above WAC, you're -- you're saying that it's a 30-percent yardstick relationship. There's --

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there will be a relationship to WAC, and ASP may differ from WAC, and that would be something one would find on a case-by-case basis. But the -- the yardsticks and the -- and the information that's -- that is central to reimbursement is not WAC.

What gets hardwired into the computers for paying these claims is AWP. And frankly, this is knowledge that may have been out there, you know, in the -- it certainly was -- I guess was -- is -- was published and would have been listed.

There are some cases when one of the prices is not listed. It might not be -- it might be one or -- I think AWP is always listed. Whether WAC is listed or not, I'm not sure. But certainly the programs are going to be computerized on the part of the payer's part toward AWP.

Q. Doctor Hartman, did you ever look at what the published spread was between AWP and WAC for Remicade?

A. I recall that I did.

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Q. So, you knew it was 30 percent before you came in here today.

MR. NALVEN: Objection.

A. I -- the -- the fact that this is a focal point of this set of questions seems to remind me that I'd looked -- remembered seeing a drug where there was a difference between WAC and AWP of 30 percent, and I can't recall that it's Remicade, but given that you're -- we're talking as much about Remicade, I'm assuming that was the drug where I noticed that.

Q. And do you have an opinion as to how third-party payers would have reacted to learning that physicians were actually acquiring Remicade at anywhere from 1.9 to 6 percent below the published WAC?

MR. NALVEN: Objection. Asked and answered.

A. Yeah. I mean, it's -- I think it's been asked and answered.

Q. Would it be reasonable for a third-party payer that was receiving rebates of 1 to 5 percent

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on Remicade to understand that physicians may well have also been receiving discounts in that same range --

MR. NALVEN: Objection.

A. Your --

Q. -- off of WAC?

MR. NALVEN: Objection.

A. The -- your hypothetical is counter to my understanding of how rebates are paid for physician-administered drugs; that third-party payers do not receive -- significant rebates are not being paid or --

Q. Doctor, you keep talking about significant. We're looking here at differences off of WAC of 1 to 6 percent. You'd agree with me those are not significant, right?

A. If -- let's put this -- why don't we put this -- what we're talking about here is whether -- whether the -- what the bright line of the threshold of liability is, and you're telling me, you know, look, there's relationships across drugs of -- between AWP and WAC of 20 percent, and also

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of 25 percent. Now, that's -- so, there's a difference there, and that's known.

Now, the question is if -- if there's some other rebates paid or some other financial incentives paid, does that push the -- the understanding between -- of what payers had thought the relationship between AWP and ASP was, is it -- does it lead to a value above the threshold that I've used for liability?

And so, the fact that it goes from 20 to 25 percent doesn't suddenly change things substantially. There are -- there are a range of relationships between AWP and WAC that have essentially informed how reimbursement rates are set, and the fact that Remicade has come along and set their WAC -- their AWP relationship -- AWP/WAC relationship at 30 percent, it's -- they could have been -- there could have been financial transactions or payments that would have dropped the spread down to 29.7 percent or raised it here to -- we have 31.9 percent.

You -- you are correct in saying that

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for the drug Remicade, they are very -- they're close to the -- the threshold of liability that has been -- that I have used and developed in my declaration and they're --

Q. That --

A. -- exceeding it by -- so you're saying, look, should Remicade be given a ticket because they exceeded the speed limit by -- by 2 percent?

Q. Doctor, you want to focus on your yardstick. I'm focusing on the publicly-available information which was that the relationship between AWP and WAC was 30 percent. You told me in the beginning that was information that was known to third-party payers, correct?

MR. NALVEN: Objection.

A. The -- that was information that was published. If you're telling me did -- did third-party payers spend the time to look at every physician-administered drug and raise to the level of -- of their consciousness and reimbursement formula about how -- what they're going to do and what they're going to pay and how -- what they

1201

think the relationship to ASP is, that, bang, Remicade popped up, and this was a matter for their committees to make decisions about altering the reimbursement rates or what their understanding of the relationship of AWP to ASP was, I'd say, even though that's published that that was not something that was -- was a major determinant in how reimbursement rates were to be -- be related to ASP.

Q. Doctor Hartman, can you -- can you tell us the third-party payers that you spoke to with respect to Remicade.

A. The -- I have -- I have not spoken to a single third-party payer regarding Remicade.

Q. Well, you just told us that you have an opinion as to how third-party payers dealt with the fact that there was a published spread of 30 percent on Remicade --

MR. NALVEN: Objection.

Q. -- didn't you?

A. I -- I did.

Q. But you didn't actually talk to a third-

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party payer about Remicade, did you?
MR. NALVEN: Objection.
A. One -- what -- that question is about as -- makes about as much sense as saying that someone who studies any industry, the steel industry, who studies the automotive industry and studies a -- a variety of documentation and discovery materials coming from a variety of different sources about all types of different products, and then suddenly saying -- and being able to see summaries of how a market works, what the structure and the performance of that market is, and then saying, Oh, now you can't draw a conclusion about how -- how the -- how BMW dealt with its -- its 330 series, because you didn't talk to a dealer about the BMW 330.
There are -- one can go to the documents that I have reviewed and the analyses that have been incorporated and listed in great detail from the beginning of my -- my class cert. declaration to understand what is important generally to third-party payers and to the various entities in

1203

this market. And I'm basing it on that. And I don't need to -- I didn't -- I didn't talk to the third-party payers about the -- one particular NDC of Procrit or another particular NDC of another drug. That doesn't mean I can't draw conclusions about it or any economist can't draw conclusions in that fashion.
Q. Doctor Hartman, is it more expensive to administer Remicade in the hospital setting or in a physician's office?
MR. NALVEN: Objection.
A. Since we have excluded all administration through hospitals, it was something that I -- we didn't -- we didn't focus on.
Q. In setting a reimbursement rate for Remicade administration in a physician's office, is -- would a third-party payer consider the relative cost to it of administering it in a hospital as opposed to in a physician's office?
A. Are you saying when a physician -- when a provider is negotiating with payers to -- when it's going to be administering Remicade, does it

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take into account how difficult it is to administer in terms of negotiating the -- the service fees?
Q. Will a -- will a third-party provider look at whether it is --
A. A third-party provider or payer?
Q. Payer, I'm sorry -- whether it would be more expensive or less expensive to administer it in a hospital, as opposed to in a physician's office?
MR. NALVEN: Objection.
A. The -- a third-party payer is going to negotiate contracts with providers, and those providers are oncology groups and physician groups. And those are the -- those are the groups that have been included in the -- the sales through which all of these drugs are administered. And so, a negotiation with a third-party payer with a hospital, I would assume, is different than with a single doctor or with a group of -- a group practice or an oncology group.
Q. Assume that it costs less to administer

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Remicade in a physician's office than in a hospital. Would this provide an incentive to third-party payers to allow physicians to make a profit on Remicade?
MR. NALVEN: Objection.
A. If -- you're saying if it's -- if it's cheaper to administer Remicade in a provider's office rather than in a hospital and the -- and so you're -- would it make sense for --
Q. Would it make sense for the third-party payer to provide an incentive for in-office utilization of Remicade, as opposed to hospital utilization?
A. The -- if -- if third-party payers were focused -- focusing on Remicade and making -- and trying to incentivize providers to -- to administer it in the office setting rather than as an inpatient, and as an inpatient seems like it would -- that's determined by totally different --
Q. No, I'm talking about a hospital outpatient clinic setting.
A. Okay. Which, again, we've excluded from

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our damage calculations here, but if there are certain venues through which a payer felt it was cheaper to do, there would be -- there would be -- it could be in their interest to negotiate incentives to try and get physicians to do that.

Q. Did third-party payers expect that physicians were making a profit on Remicade?

A. I would assume and what has been built into my yardstick that third-party payers assumed that physicians were making what Mr. Young has characterized the retail margin or some -- some margin on -- on the drugs being reimbursed in the provider setting. The problem with this -- with the -- the alleged inflation -- fraudulent inflation here was that they didn't understand the extent of that profit.

Q. So, for Remicade, payers understood that a profit was being made up to a -- strike that. So, am I correct that third-party payers understood that within a framework of a spread of 30 percent, there was some physician profit built into it?

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A. Payers understood that overall the -- their -- their understanding was that at a -- at reimbursement rates of anywhere from 20 to 27 percent of AWP -- of discounts off of AWP, that there is going to be some profit for the physicians. And that's across all drugs. Now, some would offer a little more. Some would offer a little less. And I'm not sure that Remicade entered onto the radar screen saying we're going to -- we're going to focus our -- our average reimbursement policy that's going to cover all physician-administered drugs that you're doing in your -- in a -- in a particular physician setting that -- based only on what you know about the profit being made on Remicade.

Q. Well, you'd agree with me, wouldn't you, Doctor, that Remicade was a little different from other physician-administered drugs in that it was being administered by rheumatologists? And there are not many physician-administered rheumatology drugs, are there?

A. The extent to the number of rheumatology

1208

drugs that are available, I -- I couldn't say.

Q. Let me just ask you a few questions about your data. Can you turn to Page 9.

A. 9 of the declaration or of the -- of the --

Q. Of G-4.

A. G -- okay. Okay.

Q. You say in the third bullet point, "Charge-backs were not excluded where COT codes did not match with a customer number." What --

A. I'm sorry.

Q. Why didn't you exclude those?

A. I'm sorry. Let me just see where --

Q. Page 9.

A. Right. Which bullet? How many down?

Q. Third.

A. Third bullet down. Okay. Got it.

Q. You see, "Charge-backs were not excluded where COT codes did not match with a customer number." And my question is, why wouldn't you exclude them if you don't -- if you don't, in fact, know the customer number associated with

1209

that charge-back?

A. Just give me a chance, 'cause it has -- it's fitting into the whole context of the -- of the analysis. I just want to follow -- (Witness reviews document.) I'm sorry. I haven't committed all of these particular calculations to memory. This is something I will have to -- I'd have to check with my analytic team. I can't interpret this sufficiently right now without inquiring of them what -- what procedure they were basing this on. They -- they were on the phone with -- with Defendants with some regularity trying to work through the various databases. So, I can easily let you know that, but I can't answer that at the moment.

Q. Can you turn to Page 3.

A. Let me just make a note of this so that I --

Q. Sure.

A. -- do respond to it. Incidentally, there were errata that were passed out for some of the calculations and some of the data, but it

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certainly didn't address this. Okay. I'm sorry. Go ahead.
Q. Turn to Page 3.
A. Okay.
Q. Under the heading "All Drugs Analysis," am I correct that there were instances in which there were multiple COT codes for a unique customer code?
A. And you're basing that on reading where? Which bullet?
Q. The first bullet point --
A. Yeah.
Q. -- I believe suggests that.
A. It says, "Files containing customer numbers, customer names, and class of trade codes were combined into one data set, keeping only one record per customer number." And so, what that says to me is that for a given customer name and customer -- and class of trade code, one record was kept so that a given customer number could appear with the -- in a different classes of trade, and it would be kept in the data unless it

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were blank.
But if you want me to confirm that in greater --
Q. Well, that -- well, let me ask you this question: Were there instances in which you had multiple COT codes for a unique customer code?
A. For a customer name or a customer number -- customer code?
Q. Customer code.
A. I would assume there would have been, and they would have been kept, but for -- the one number per customer code is how I'm reading that.
Q. Then how did you determine what class of trade to put that customer in?
A. Well, it was the sales to the class of trade. There's going to be different sales to -- I would assume there are going to be some customers that could appear in different classes of trade, and there will be certain units that you're attributing to each of those based on your accounting practices and procedures.
If that is an incorrect interpretation

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of -- of our understanding of your data based on our conversations, then we would like to know that, and we can -- we can respond accordingly.
Q. So, is it your understanding that where you had a unique customer code with multiple COTs, you would allocate that customer sales in different classes of trade?
A. Well, the -- it's -- this is keeping only one record per customer name within a class of trade, and so, I'm assuming -- I'm reading this and assuming that my staff were given instructions that there could have been sales to some specific customers that could -- and certain sales were classed as part of -- within one class of trade or another class of trade. And both of those -- and that those sales were separated by your accounting practices and procedures for reasons that were important to you, and we -- we treated it as such.
Q. Were -- were there instances in --
A. But let me just write that one down, and I can confirm --
Q. Okay.

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A. -- that understanding for you. Okay.
Q. Were there instances in which there was a unique customer code that had varying customer names?
A. I would have to ask my staff to do a run to check that.
Q. So, you don't -- if that situation exists, you don't know how that was addressed.
A. If you want me to take the time, the -- the staff was given directions to approach this in a consistent manner, and it's reflected in this description. If it's not -- if it's not fully clarified herein, we can either respond to written questions, and we'd be glad to tell you how that is -- was treated. But obviously, if -- if this is not enough for me to fully see it, it's -- it's because, in response to whatever questions they asked of -- of you and your clients, we -- we could use the data to the extent that we did, but it wouldn't surprise me that we could have used further information. And I know we were always in the process of trying to get further information.

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So, if -- if there's a question pending, I'd be glad to respond to it in a follow-up. Do you want me to --

Q. Yeah. I'll take you up on your offer to accept some written questions on -- with respect to data.

Let me ask you to turn to Page 11. Under Table 1, these are the classes of trade codes that you excluded from your calculation of ASP, correct?

A. That's right.

Q. All right. And your intention here would have been to exclude, for example, all -- all federal government contracts?

A. That's correct.

Q. So, it would have been your intention to exclude codes that related to the public health service, VA Depot, military allocation, correct?

A. We -- as I've discussed in the -- in the text, there were -- we were -- we tried -- we focused this on -- on providers that would submit reimbursement to third-party payers. And so, we

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excluded hospitals. We excluded government. We excluded the -- the categories that you're talking about. We excluded direct purchasers like -- and staff model HMOs like Kaiser.

We used the class of trade codes where we could to do that. We used account names where the -- we felt that gave us additional exclusions.

Q. The -- we've noted a difference in the managed care rebates in your Declaration 1 and Declaration 2. Would there be any reason why the managed -- your calculation of managed care rebates would be any different in the two declarations?

A. You mean the supplemental and the --

Q. Yes.

A. The -- the instructions I was given for the supplemental declaration to inform that analysis I've expressed fairly explicitly, and they were directions --

Q. But is there any reason why the rebate, the actual calculation of rebate dollars would be -- would be different?

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A. If we're talking about an ASP-calculated overall sales, well, then as part of that ASP you'd include rebates across all sales. And so, if I'm including hospitals and other things and everything except government, then I would include charge-backs and all the other things that were excluded before, which I explicitly identified --

Q. I understand the difference, but I'm talking about the -- is there any reason why with respect to the same managed care entities you would come up with different rebate levels -- rebate amounts in your first report and in your second report?

A. In the -- to the extent that we were attempting to identify a subset of units sold in a conservative fashion and exclude all -- all possible -- excluding all hospitals so that we -- so we're losing some sales and being conservative with respect to actual outpatient units that were reimbursed, there may have been some -- some of the entities you're talking about where some portion of those sales -- where we based them on

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charge-back data or we did some allocation -- were excluded. Some stayed in.

Then once we went to the full, we just said look, we're including everything except government in the supplemental report, then all of those rebates came back in. So the rebate dollars could differ.

Q. Okay.

A. And I'd have to -- I'd have to look exactly at the -- at the entities excluded and then included and what those rebate dollars were.

Q. All right. Turn to Table 2.

A. Yeah.

Q. Am I correct Table 2 is a -- is an attempt to exclude -- strike that. Table 2 is a list of the entities for which rebate data was excluded from your ASP calculation, correct?

A. These were -- that's true.

Q. And it would be appropriate in each year to exclude these entities, correct?

A. And to the extent that we were able to, we did so. To the extent the data allowed us to,

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that would have been our --
Q. Okay.
A. -- what was our attempt.
Q. Let me ask you to turn to G.4.C, the calculation of the spreads.
A. Okay.
Q. See for the year 1993 --
A. I do.
Q. -- for a particular NDC you calculate a spread of 221 percent.
A. I do see that.
Q. And for another one, 51 percent.
A. I do see that.
Q. Would you agree with me that looking at the approximately more than 125 spread entries you have for Procrit on this page, those truly stand out?
MR. NALVEN: Objection.
A. They are certainly larger than the other spreads, but I see other spreads -- I see a spread for 66 percent in 2003 for a -- for another one. There are -- but the -- the extent to which the

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spreads for Procrit over this period of time on an annual basis exceed the -- the threshold of liability that -- that I've used, are -- are limited.
Q. Would -- would you agree with me -- well, let me ask this: When you saw spreads like 221 percent for a given year when for that NDC the spreads then range from 20 to 24 percent, did you go back and say maybe there's an error in the data here? Let me double-check that? Did you do that?
A. We attempted to check all the data that we received and -- well, we did. We did check all the data that we received.
Q. No, I'm asking about you. When you looked at these, did you say, Wow, that 221 percent spread really stands out here, let me go back and make sure the data's right? Did you do that?
A. Did I go drug by drug, company by company and say, well, let's see, I'm seeing a pattern here where one spread was large and then might have drifted down and then dropped below and

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then might have changed, or there might have been a spike in the spread, and did I then say, Let's need to look at the data underlying that and try and get further confirmation of that data? We did not follow up with that kind of analysis where we proceeded year by year, drug -- NDC by NDC.
We -- we checked the data that we received several times. And if there was -- if there was something wrong -- and we -- in order to be conservative and look at spread calculations as a strategic matter that is unsullied by month-to-month or quarter-to-quarter variation, we took an annual spread amount.
Now, if there is something in a particular spread here in a given year that is based on something wrong with the data we received -- we weren't in a position to correct data that we received from Defendants.
Q. Doctor --
A. And if this is the case, I assume your expert will clarify this in rebuttal.
Q. Doctor Hartman, my question was very

1221

simple. Did you -- you, not we -- did you, when you saw a 221-percent spread for the year 1993, and for that NDC, all the other spreads are between 20 and 24 percent, did you go back to your staff and say, Hey, this doesn't look right, let's go back and look at the data? Did you do that, Doctor?
MR. NALVEN: Objection.
A. Well, you're premising -- you're premising that that it didn't look right.
Q. Well, does it look right to you?
A. I don't know what J&J was trying to do that particular year. I've seen spreads with Lupron. I've seen in some of this litigation where Lupron has jacked up the spreads for certain NDCs to 4 or 500 percent and then dropped them down to zero or to negative amounts over years when they start pushing other NDCs. So, I'm not going to second-guess your data. That's -- I've looked at some -- I've looked at different patterns of spreads across the various Defendants, and if there was something that stood out, I would

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have it checked a second time. But I was not going to change that, and I had no information upon which to say what that should be.

And I assume that will be what your expert will do.

Q. Now, if we look at the Procrit numbers -- I think I counted there's roughly over 125 entries here.

A. You know, I'll --

MR. NALVEN: It is what it is.

A. It is what it is.

Q. Just assume --

A. Let's assume --

Q. And would you agree with me that less than 10 percent of them are over your -- your yardstick of 30 percent?

MR. NALVEN: Objection. The document speaks for itself. It is what it is.

Q. Well, okay. So, assume for purposes of my question that less than 10 percent of them are above the 30 -- your 30-percent yardstick, would you agree with me that as you look at Procrit, you

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don't see a pattern of behavior in exploiting the spread?

A. Certainly more of the -- the -- the spreads here are below the -- the yardstick for liability than are above it. And, I mean, we could count it and find out whatever percentage it is and --

Q. Well, I've asked you to assume for purposes of my question that it's less than 10 percent of the over 125 entries -- spread entries -- that you have on this page.

If my math is right, would you agree with me that there is no pattern of behavior on the part of Johnson & Johnson in exploiting the spread on Procrit?

MR. NALVEN: Objection.

A. I wouldn't character -- I wouldn't characterize that there's no pattern. There's -- the pattern is what it is. It's the limited -- whatever number -- whatever percentage you're giving me, that's what the pattern is.

Q. Well, you testified yesterday that, in

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looking at certain drugs, you observed a pattern of behavior of exploiting the spread. My question to you is, based on the data you see here for Procrit, do you see a pattern of behavior in exploiting the spread?

MR. NALVEN: Objection.

A. I see an exploitation of the spread here that is certainly -- there are times -- there are times when the spread has been exploited. And it is -- it is -- if one is comparing this pattern relative to other patterns that I've seen, it is -- there is certainly less exploitation of the spread here than I've seen for -- in other -- for other manufacturers.

Q. Well, maybe I need to get your definition of the word "pattern," because we may have different definitions. What's your definition of the word "pattern"?

A. Well, I'm -- I am looking -- it's -- it's fairly simple. It's exceeding the -- the thresholds of liability and what that means.

Q. So, if --

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A. And I can look at -- I could look at a pattern in a quilt where there's a few spots of color or there's lots of spots of color. This is one where there's -- there are certainly fewer times when the -- when the threshold of liability is exceeded.

Q. Let me just turn back to Remicade for a moment. In your opinion, would third-party payers change their reimbursement rate for Remicade upon learning that the spread was 31.9 percent instead of 30 percent?

MR. NALVEN: Objection.

A. For -- for Remicade -- you're -- you're saying would they change their reimbursement for Remicade per -- alone --

Q. Yeah.

A. The -- as -- as we've discussed at some length over the last two days, what gets formalized in an institutional understanding of what the spreads are, what the reimbursement rates that are agreed to, AWP less a certain percent. And the -- the notion that they're going to

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observe a spread of 31.9 in one particular year, if they were to observe that -- again, they'd have to have the data that -- the manufacturing data that we have. We've already talked at some length about limited information from the OIG that said, Oh, spread on this particular drug in this year was this level or something else. All of that did not lead to a change in the reimbursement policies, and I don't -- and for physician -- the -- payers do not negotiate contracts, as far as I understand, for specific drugs in what their reimbursement policies are. They're AWP less something for physician-administered drugs.

So, to know that for one year, it would be -- the -- you'd need to know the kinds of information that we've talked about much more broadly that's led to the changes in reimbursement formulae that -- recently.

Q. All right. Let me go back to Procrit for a moment. Assume for the moment that there's roughly 125 spread entries here. How many have to be above 30 before there is a pattern, in your

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view?

MR. NALVEN: Objection.

A. I haven't -- I haven't been asked to render an opinion of -- of whether -- what's a pattern or what's not a pattern. What I've been asked to render an opinion on is what's -- what's a violation of -- of -- under the -- the allegations in this matter, given the understanding of the market, as reflected in reimbursement rates. So that, if I looked at a given manufacturer with a drug that has a 2,000 -- 200 entries here, and there's only 5 percent of the time where that -- that manufacturer exploited the spread for whatever reason for those years, then that's -- that's the threshold for that year.

I have not said at any place that in order for there to be finding of liability the -- the threshold needed to be exceeded five straight years.

Q. So, when -- when you were referring to a pattern of behavior yesterday, you're not really giving any opinions with respect to patterns of

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behavior here? That was just rhetorical flourish on your part?

MR. NALVEN: Objection.

A. It was not rhetorical flourish. There -- I've referred to patterns, and the patterns are spreads that are in excess of 30 percent. And some of the patterns are more. There's a more predominant finding of spreads in excess of 30 percent. In some, there's less. It's a different -- it's a different pattern.

Q. Well, for Procrit, show me the pattern.

A. Well, I'm finding in particular years that there was -- if -- if the data that we have received is correct, there were reasons that the firm -- that Johnson & Johnson -- used the spread to move market share in those years. And they -- for whatever strategic reasons; I don't know why they -- why they backed off of -- for that particular NDC that we've looked at for 221.

There are other -- there's movements and I see increases in spreads for other NDCs for Procrit. If I look below that at the NDC that has

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a spread of 23.3 in 1993, I'm seeing that as the spread for the NDC that had the -- the spread of 221 percent, that declines.

Now, I'm seeing a spread for this -- the -- this other drug that started at 23.3 rise. Now, there's a pattern to me there --

Q. And then --

A. -- of using spread to shift sales and move market share of particular NDCs that I've seen used to greater extremes by other Defendants, but there's patterns of movement here that --

Q. Well, let's talk about that 23.3 that you're talking about, which is the Procrit 3,000, 25s.

A. That's right.

Q. So, in '93 it's 23.3; then in '94, it's 27, still within your -- still within your yardstick; '95, still within your yardstick; '96 goes above your yardstick by 1 percent; and then for the next one, two, three, four -- four years it's below your yardstick; then it goes over it by .4, and then it's below it. So, for how many

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years are we talking about? We're talking about one, two, three, four, five, six, seven, eight, nine, ten.

So, for ten years you have -- you go over your yardstick. One year by .4 percent, and one year by 1 percent. What's the pattern there, Doctor?

MR. NALVEN: Objection.

A. Well, the pattern there is, first of all, I can't observe whether there were -- what -- what -- whether we received the data or whether there were sales of the 2,000 milliliter -- am I looking -- the 2,000 milliliter six-pack? I guess they're sixes of the 221 percent.

I'm seeing here that in 1993 -- whether this had launched prior to that, I don't know. Whether we got the data, I don't know. I'd have to look at whether we did some extrapolation there or not. But this suggests to me that there were certain -- in this particular year, '93, there were certain NDCs that -- we see the one for 51 percent.

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Now, I'm seeing the pattern here is a strategic move toward the 4,000 milliliter sixes, if I've got the right line. I'm sorry. It's the 3,000 milliliter 25s, and we're seeing that that spread is increasing but remaining within what expectations were. So that it hasn't -- it hasn't violated the -- the expectations of the market. They're still competing on spread, but they're doing it within the bounds that are subject to my -- to my legal threshold.

Q. So --

A. They did push it above that in '96, but it's -- it's clear they were -- relative to the 2,000 milliliters where they were reducing the spread down to 24, they were using higher spreads on the 3,000s, and that suggests to me that there's a pattern there of moving market share of one versus the other.

Q. In the NDC that we were just talking about where we were talking about a ten-year period, one year they went over by 1 percent and one year they went over by .4 percent of your --

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your yardstick threshold. Are you saying that Johnson & Johnson made a decision in those two years by going over by .4 and 1 percent to commit fraud, and in the other eight years they decided not to commit fraud?

MR. NALVEN: Objection.

A. The -- what -- what I'm saying is that relative -- when -- when we've talked spreads that would flabbergast people, these would not flabbergast people. The point -- but given the expectations of the market and what was understood by the market, the -- the -- as they -- as they moved up and started to try and move market share, they nudged against the speed limit. They pushed it a little further than what expectations were.

And they didn't exceed it by much, and so the damages are not -- you know, the damages on this amount are not going to be a whole heck of a lot, as the speeding ticket would not be a whole heck of a lot. They did not -- this is not an example of the exploitation of spread to the extent that other manufacturers have used. But it

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still is a use of spread in excess of what payers understood. They were keeping it well under radar. It was not -- it was not an exaggerated exploitation.

MR. NALVEN: Mr. Cavanaugh, if I may, at the beginning of this session you said you had about 45 minutes of questioning.

MR. CAVANAUGH: And I have about three more questions for the minutes.

MR. NALVEN: It's been about 75 minutes now.

Q. Doctor Hartman, in your speeding analogy which you've used many times here, where was the speeding limit posted on the street that said do not exceed 30? Can you tell us where is it posted?

A. It was posted in -- well, let's step back about what was posted. There were a set of expectations which characterized what people were -- what payers thought were being -- what relationships were and what providers were receiving and paying as acquisition costs for

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drugs. And so, the speed limit was an implicit understanding built into the reimbursement formula -- formulae -- of payers and -- of payers.

Q. Are you saying that manufacturers understood that there was a speed limit of 30?

A. I'm saying that manufacturers understood that payers had certain expectations, and the upper bounds -- I'm using an upper bound of what those expectations were. I'm saying that the expectations ranged anywhere from 18 to 26 percent, 27 percent. I'm being conservative to say, okay, let's take 30 percent. But that they understood that and that that was -- that knowing that, and knowing that the -- that the payers were not going to know that they were speeding or that they were -- they were exceeding that, that was the reason that the -- the alleged fraud allowed them to -- to use that inflation to move market share.

Q. If -- if we use your -- stick with your speeding analogy for a moment, would it be fair to characterize it as there was a -- a sign -- this

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implicit sign posted that said 30 miles an hour for private payers, and for government, the speed limit was zero? Is that a fair characterization of your -- of your analysis here in -- in your speeding context?

MR. NALVEN: Objection.

A. A fair -- a fair analysis of my speeding context -- of my speeding context was that there was a relationship between AWP and ASP, the maximum of which I've taken as 30 percent, a conservative upper bound. That was -- that was for all units sold. So that's for government and for nongovernment. That's what the understanding was in the market.

Q. Well, I thought your -- your opinion is that with respect to government it was zero.

A. No, my understanding with respect to government is that if -- in my declaration of December 15th, that if a drug exceeds the speed limit, then there is -- there are statutory -- if they don't exceed the speed limit, then it's not zero. The speed limit is what it is. And it only

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becomes subject to liability if it exceeds the speed limit.

Under the Medicare regulations, as reiterated in my Footnote 13, that indicates the extent to which damages would occur if the speed limit is exceeded. And that's -- that is a -- that's a -- those damages are not the threshold of behavior or liability. That's just a damage calculation, which is a different calculation, which has that zero in it based on my reading of the -- of the CFR.

Q. But in order to be -- in order to be subject to damages for Medicare Part B sales, you have to violate your speed limit of 30, right?

A. In my December 15th declaration, that was the approach, yes.

Q. Okay. And have you altered that view?

A. I have no view of what -- that is a legal view. In my supplemental declaration I was asked to assess what the implication would be for damages and liability if -- if the zero threshold applied for Medicare, but that's not -- that was

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something I was asked to do by counsel, and I have --

Q. So --

A. I have a view as what market expectations were and what everyone in the market understood transactions costs were relative to posted AWPs.

Q. So, if we have your zero -- based on your supplemental report, if you have a zero liability threshold and a 30-percent threshold liability, again, using your speeding analogy, there are two different speed limits posted on the road, right?

A. The -- the speed limit that's posted on the road is the understanding of the relationship of a list price and transactions price. And that's what's posted.

Now, the -- how policemen have enforced that speed limit, what that's -- there's -- it's a different -- the analogy would be in the supplemental I've been asked to assume that even though the -- the speed limit is 30 percent, we

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are going to -- we are going to look at certain payers, i.e., Medicare payers, and if -- if they are going zero miles an hour, if they're standing still on the highway, if the -- if we take the regs as they are written, which it's my understanding is a legal analysis and something subject for you to -- to argue -- that that is the way damages would be calculated.

MR. CAVANAUGH: Thank you, Doctor Hartman.

THE WITNESS: They're lined up like planes in LaGuardia.

MR. NALVEN: Let's take a break.

VIDEO OPERATOR: The time is 11:05. This is the end of Cassette 1. We are off the record.

(Recess was taken.)

VIDEO OPERATOR: The time is 11:17. This is the beginning of Cassette 2 in the deposition of Raymond Hartman. We are on the record.

FURTHER EXAMINATION

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BY MR. HEROLD:

Q. Good morning, Doctor Hartman. My name is Fred Herold with the law firm of Dechert. I represent GlaxoSmithKline in this case.

A. Good morning, Fred.

Q. Good morning. I'm going to be asking you some questions this morning, both about the MDL case -- about the work you did in the MDL, as well was about the Connecticut case, because GlaxoSmithKline is a Defendant in both cases. I want to start, Doctor Hartman, with some follow-up on the questions about your expectations that Bill Cavanaugh just asked you. First of all, I think you -- you testified that it's your opinion as an economist that everyone in the market, all different payer types understood the way the market worked with respect to your expectations yardstick, is that right?

A. No.

Q. Okay. Why isn't that right?

A. Well, it -- the various payers and various entities in the market had varying

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expectations, which -- which we see through revealed behavior as different contracts have been able to be negotiated for reimbursement off of AWP. So, part of that negotiation was informed by different beliefs, different amounts of information. What I've taken for my yardstick is an upper bound of what I saw as a range of what the under -- the various understandings and beliefs were about that.

So, they -- everybody in the market didn't hold the same belief or expectation. They varied, and I -- I took an upper bound of what that -- what that range was.

Q. Okay. Fair enough. Is it your opinion, however, that the different types of payers generally held the same expectations? In other words, what I'm getting at is you testified or you -- you've testified at length that it's your opinion as an economist that both third-party payers and Medicare would be subject to the same 30 percent expectation, is that right?

A. I'm -- I've testified that the -- that's

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a summary -- an upper bound of expectations in the market. So, that's everybody.

Q. All right. And when you say, "everybody," it would include governmental payers as well as private payers.

A. That's correct.

Q. All right. And you, in fact, rely on the same studies, comparator drugs, government studies, I believe ASCO and other things in your report in determining the expectations of the different segments of the market, i.e., government versus private, is that correct?

A. I look to those studies that were done by the government -- inform not only the government but inform the private sector to the extent that the private sector avails themselves of those types of studies for this very specialized group of drugs. So, the -- again, there's information out there and -- and it's -- it's -- it's available to payers to the extent that they want to make it available.

I mean, for a case in point, you're

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saying are types of third-party payers. I know we introduced deposition testimony yesterday that included a deponent from CIGNA. And the -- as I had reviewed -- or maybe this was on Monday. As I looked at that deponent's credentials, they were -- there did not seem to be a lot of experience in the health care area. There was perhaps very capable experience elsewhere. And that would be someone who might have less of an understanding -- you know, there's information out there, but it might be someone who studied it less, is less familiar with the nuances.

So, the information set is there. It's developed. It's how various people assimilate that and it's how it's reflected in the institutional formulations regarding the reimbursement.

Q. And with respect to your opinions about liability, I just want to make sure I understand the different visions we have here. With respect to your opinions about liability, am I correct that it's your testimony that for third-party

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payers there's no liability as long as the spread on a drug does not exceed your 30-percent yardstick, is that right?

A. In my -- in the December report I have -- my finding is that -- that 30 percent is a reasonable upward bound for -- to - for a spread, and if it -- if the pricing is below that, then there's not a finding of liability for that -- for that NDC in that year.

Q. Okay. And am I correct that in your December 15th report you rendered the same opinion with respect to the acceptable spread or the upper bound as it applied to Medicare payers, is that right?

A. That -- that spread is for -- for all, you know, the understanding of the pricing relationships for all drugs. And that's right. I -- in the December report I applied it to all payers.

Q. Right. And then am I correct that in your subsequent report in the MDL -- I believe it's a February report in the MDL --

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A. In the MDL or the Connect --

Q. In the MDL.

A. My subsequent report to the December --

Q. Correct. Your supplemental report in the MDL.

A. I thought that was -- oh, I'm sorry. I thought -- I thought we jumped to Connecticut.

Q. We're still on the MDL.

A. Excuse me. I'm -- too many reports. Got it. I'm there.

Q. Okay. In your supplemental report in the MDL, am I correct that you render a different opinion with respect to the acceptable spread for liability purposes for Medicare based on the request of your counsel that you render such a different opinion?

MR. NALVEN: Objection.

A. Well, issues of liability really are the -- are the purview of counsel in this matter. I mean, I'm an economist. I can come to this market, I can talk about what informs expectations, what relationships between prices

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are, how they're formed, what -- how that gets formalized into reimbursement rates, and what's an upper end of what's reflected in what has been formalized as a -- as a level of -- of what the market understood or expected was a relationship between a list price and a transactions price. And so, I can do that as an economist, and then I can say are there drugs that have exceeded that?

And in my December 15th declaration, I was asked by counsel to use that -- those economic facts as a measure of liability. In the -- whether that really is a measure -- whether that's a liability for fraud or whatever, that seems to me something that will be -- is a legal question. It's -- I can deal with the economics.

In the supplemental report I was asked to also do an analysis looking only at the economics of it, and not using that finding, but just looking at the -- the actual language of the Medicare regulations in calculating what the damages were and not allowing for this (indicating) economic analysis of the 30 percent.